# Delayed psychiatric sequelae among Falklands war veterans

GARETH H. JONES, MRCP, MRCPsych
Senior Lecturer, Department of Psychological Medicine, University of Wales College of Medicine

JONATHAN W.T. LOVETT, MRCPsych
Registrar, Department of Psychological Medicine, University of Wales College of Medicine

*SUMMARY. The only published account to date of psychiatric complications among Falklands war veterans suggests that acute reactions are rare. Reported here are three cases of severe delayed reactions in Falklands veterans from South Wales. All three cases demonstrate a common pattern similar to that shown by Vietnam war veterans. Possible aetiological factors and prevention are discussed. It seems likely that relatives of combatants will also be affected and general practitioners are in a unique position to recognize and treat these problems.*

## Introduction

THE only published account of psychiatric sequelae among Falklands war veterans,[1] stresses the low rate of psychiatric casualties. The American author attributed this to the brief nature of the conflict, the elite character of the units involved and the continuing high morale induced by continuing successful advances, but he does not mention delayed reactions. A review of the British literature by Patrick and Heaf[2] indicates that delayed psychiatric responses, particularly anxiety neuroses, are likely among war veterans. The American experience following the Vietnam war has led to the acceptance of delayed post traumatic stress disorder in the American Psychiatric Association's *Diagnostic and statistical manual of mental disorders.*[3] Indeed, in 1980 the Veterans Administration accepted that veterans with this disorder deserved a war pension.

Patrick and Heaf[2] conclude that there is 'a paucity of research on war victims'. We therefore present three cases of delayed psychiatric sequelae that we came across by chance in Falklands veterans from South Wales, an area particularly affected by the heavy losses of the Welsh Guards.

## Case 1

A 19-year-old Welsh Guard was blown out of a below decks compartment on the assault ship *Sir Galahad* by a bomb blast. He suffered only singeing of the hair and eyebrows but he returned to the compartment to find the mutilated remains of his best friend, a married man with a young child. Despite the shock he carried wounded survivors on deck and gave them first aid. Other friends of his were trapped below decks and he had to listen as they were killed by fire and exploding ammunition. Less than half his unit survived. He rowed the wounded ashore, many with severe burns to face and hands, and helped them into a hospital tent.

By the time he returned home his hair and eyebrows had regrown and he was left without a scar. He visited his best friend's widow and child, and found himself wishing that he had been killed and his friend allowed to live. A presentation from his local Council made him feel guilty at surviving unscathed, and he was further upset by seeing action from the Falklands war on television, and by a programme analysing the mistakes of Bluff Cove where *Sir Galahad* was sunk.

He started to shake and sweat a lot, and he suffered palpitations. At night he could not sleep, and when he was at home on leave he would spend all night walking over the mountains seeing the full horror, as if it were a film. There were rows at home, and he could not discuss his problems with his family. He increased his daily alcohol intake to nine pints of beer and several shorts. This did not help him to sleep and led to vomiting and weight loss.

He had not suffered from a nervous problem or a drink problem in the past, but his family history included a father who had suffered from mild anxiety many years previously.

When he was seen on a domiciliary visit during his leave, he seemed to have difficulty linking his experiences to the way he felt. He refused to consult an army doctor, and would not attend a civilian clinic on his next leave. However, he promised to talk over his problems with a friend outside his family that he felt he could trust.

## Case 2

A 36-year-old naval steward was a first aid orderly on HMS *Antelope* when a bomb with a faulty fuse decapitated his friend and wounded all the other members of his party. He was not wounded at that time. Later, however the same bomb exploded killing a bomb disposal officer, and the steward was blown into the water. He was treated for a fractured jaw and traumatic deafness at the beach field hospital, which was regularly attacked from the air.

While returning to the UK on the *Queen Elizabeth II* he started drinking heavily, and this continued after he was discharged from the Navy because of his deafness. He suffered vivid nightmares, reliving his experience in the Falklands war, and flashbacks which could be triggered by reminders such as a television news report on a bombing by the Irish Republican Army. He had marked feelings of guilt about a comrade who had died alongside him and he meditated upon the chain of events which he argued made him responsible for that death. He was both anxious and depressed, he was irritable and he had violent rages. On one occasion, when sober, he threatened his general practitioner, holding a knife in each hand.

His heavy drinking led to difficulties in his civilian job, there were new problems with his marriage and he eventually had to be admitted with alcohol dependence syndrome. Initial drying out was successful, but he then relapsed into heavy drinking and refused further counselling. This was a reactivation of a previous drink problem which had been treated in the Naval Alcoholic Unit at Plymouth some years earlier. After the treatment he had been passed fit for active naval service and had been 'dry' for six years. His family history included an alcoholic father, grandfather and great grandfather.

## Case 3

'Simon', another young Welsh Guard, chose to reveal his problems on BBC television while they developed. He suffered 40%

burns in a bomb blast below decks on *Sir Galahad,* and was the only survivor from one of the stern compartments. His face, hands and scalp were especially affected. Following emergency surgery on the hospital ship SS *Uganda,* he was air-lifted back to Britain and underwent a protracted course of plastic surgery and physiotherapy.

He received tremendous support from his family and neighbours in his Welsh village, but broke off his engagement to an English girl. He seemed to feel that local people would judge him by his former self, whereas in a strange place he would be seen as no more than a crippled soldier with bad facial scars. He became moody, irritable and sleepless, frequently quarrelling with his mother, who was his main support. He drank to excess, and it was only when drunk that he could talk of his guilt at surviving. While drunk he revealed that his worst hand burns were sustained as he attempted to push his burning friends to safety but that he had had to leave them eventually.

## Discussion

These three young men presented with neurotic disorders which had many features in common, and began six months or more after unusually severe life-threatening stress. They suffered from a mixture of anxiety and depression with some somatic symptoms, frequent flashbacks to their experiences, and guilt at having survived. They also showed difficulty in grieving over lost comrades and their irritability led to family and employment problems. This syndrome corresponds to the American description of delayed post traumatic stress disorder and follows the pattern described by Black in a study of more than 1000 Vietnam war veterans.[4]

Only Case 2 had had previous psychiatric illness, for which he had been successfully treated and passed fit for active service. All three had resorted to alcohol to suppress their symptoms and 'Simon' could only talk of his experience under the influence of alcohol.

That we came across these cases by chance suggests that they may well represent the tip of the iceberg. The comfortable conclusion that the Falklands war had remarkably few psychiatric casualties is not tenable.

One possible contributory factor is the psychological ambience of the armed forces. Preparation for battle involves instillation of a sense of *esprit de corps,* so that the soldier, especially the young recruit, is more concerned at loss of face before his comrades than the prospect of his death or mutilation. However, this sense of group identity leads to a severe sense of bereavement when a soldier loses comrades and the normal resolution of grief through weeping is likely to be discouraged.

In addition, all three of the cases reported here found it impossible to report emotional distress to a service doctor, who is inevitably handicapped by his position in the service hierarchy. We found it surprising that despite the work of army psychiatrists 40 years ago on the importance of front-line diagnosis and treatment of war neuroses (including acute abreaction[5]), there were no Royal Army Medical Corps psychiatrists in the Falklands war.[1]

Heavy use of alcohol is a feature of Army and Navy mess life, and is encouraged by the policy of keeping prices low in the NAAFI. The low price of cigarettes has already been commented on as a factor in the high rate of early cardiovascular disease in the Army.[6] The use of alcohol as a do-it-yourself tranquillizer is likely to perpetuate a grief reaction, and confuse its diagnosis and treatment. This is evident in all three of the cases reported here.

It is important that the delayed psychiatric casualties of the Falklands war are identified so that appropriate help can be offered. It is also important that general practitioners know of the sources of such help, in particular of the Ex-Services Mental Welfare Society, which is able to advise on war pension rights. However, the only way to ascertain the true prevalence of psychiatric casualties of the Falklands war among serving soldiers and their relatives is by epidemiological studies.

In any future conflicts it would appear essential to provide an acute counselling service after these life-threatening experiences, as did Stöfsel[7] in Holland after passengers were held hostage on a train. After their first taste of combat young people need somewhere to express their feelings, somewhere free of the limitations of discipline, free of the constraints on weeping and free of the harmful effects of heavy alcohol use.

Owing to his civilian status, the general practitioner is in a unique position to assess and treat these psychiatric casualties and if necessary refer them for specialist opinion.[8] It is likely that further problems will present for some years to come.

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**Address for correspondence**

Dr G.H. Jones, Department of Psychological Medicine, University of Wales College of Medicine, Whitchurch Hospital, Cardiff CF4 7XB.


# Fansidar in malaria prophylaxis

Prophylactic advice for visitors to areas endemic for chloroquine-resistant falciparum malaria is already difficult, and the problem has been increased by recent evidence on the frequency of side-effects to Fansidar (pyrimethamine, Roche).

A survey in the USA showed that several deaths due to Stevens-Johnson syndrome, erythema multiforme or toxic-epidermal necrolysis had occurred in those taking Fansidar since the drug became available on the American market in 1982. The fatality rate is estimated to be between 1 in 18 000 and 1 in 26 000, in those receiving Fansidar in the USA. Such a level is unacceptably high for a prophylactic under most circumstances, and has led the USA to suggest the use of chloroquine for short-term visitors even to chloroquine-resistant *P. falciparum* areas, with a curative dose of Fansidar in the pocket, and to leave a wide range of options open for the long-term visitor to such areas.

On the basis of what is known or implied by the information at present available, it would appear advisable not to recommend Fansidar to visitors to areas of chloroquine-resistant *P. falciparum* malaria, where Fansidar or Maloprim was recommended in the past, at least until further information becomes available.

Source: PHLS Communicable Diseases Surveillance Centre. Fansidar in malaria prophylaxis. *Communicable Disease Report* 1985; weekly edition 85/20: 1.